

ALABAMA DEPARTMENT OF CORRECTIONS
MENTAL HEALTH UNIT (RTU/SU): INITIAL NURSING ASSESSMENT

Educational Assessment

Highest Grade Completed: _____ Regular Classes Special Education
 Able to Read Able to Write Able to Communicate Able to Understand Current Diagnosis
 Unable to Read Unable to Write Unable to Communicate Unable to Understand Current Diagnosis

Mental Status

Age: 21 Appears Stated Age Appears Younger Appears Older
 Dress/Grooming: Appropriate Marginal Disheveled Bizarre
 Posture: Unremarkable Rigid Stooped
 Facial: Unremarkable Hostile Worried Tearful Sad
 Eyes: Unremarkable Glances Furtively Stares Poor Eye Contact
 Motor Activity: Increased Decreased Gait Unsteady Gait Rigid Gait Slow
 Agitation Tremors Tics

General Attitude/Behavior: Spontaneous Preoccupied Suspicious Argumentative
 Self-Destructive Withdrawn Regressed Seductive Hostile

Mood / Affect: Flat Depressed Euphoric Apathetic Fearful Labile
 Blunt Inappropriate Constricted

Speech / Communication: Normal Aphasia Slurred Rapid Mute
 Flight of Ideas Confabulation Muttering Tangential Loose Associations Over Productive

Thought Content: Suicidal Thoughts/Plans Homicidal Thoughts/Plan Antisocial Attitudes
 Phobias Indecisiveness Self-Derogatory Excessive Religion Bizarre Self-Pity
 Assaultive Ideas Hypochondriasis Alienation Obsessive Blames Others Suspiciousness
 Helplessness Inadequacy Poverty of Content Ideas of Guilt No Deficit Identified

Abstract Thinking: Unimpaired Concrete impaired

Delusions: None Persecution Systematized Somatic Other _____

Hallucinations: None Auditory Visual Olfactory Tactile

Memory: Grossly Intact Inability to Concentrate Poor Recent Memory Poor Remote Memory

Insight / Judgment: Unimpaired Poor Judgment Poor Insight

Does not know reason for transfer to RTU/SU Unmotivated for Treatment

Assessment Completed by: A. Thomas Jr Date: 6/16/04

ADDITIONAL COMMENTS IN ADMISSION PROGRESS NOTES

Inmate Name <u>Hampton Randall</u>	AIS # <u>226430</u>
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ALABAMA DEPARTMENT OF CORRECTIONS
MENTAL HEALTH UNIT (RTU/SU): INITIAL NURSING ASSESSMENT

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Insight / Judgment: Unimpaired Poor Judgment Poor Insight

Does not know reason for transfer to RTU/SU Unmotivated for Treatment

Assessment Completed by: Al Thomas LPN Date: 7/07/04

ADDITIONAL COMMENTS IN ADMISSION PROGRESS NOTES

Inmate Name <u>Hampton Randall</u>	AIS # <u>220490</u>
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ALABAMA DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES
MENTAL HEALTH CONSULTATION TO DISCIPLINARY PROCESS

Inmate Name: Randall Hampton AIS#: B/m 226420

Institution: BCCF Date of Disciplinary Report: June 14, 2004

Is the inmate currently on the mental health caseload?

If Yes, referred for mental health evaluation/consultation on: June 16, 2004

Rule #38 (Indecent Exposure / Exhibitionism)

HEARING OFFICER:

Hearing officer must refer the inmate for mental health consultation if the inmate appears unable to understand what the charge is and what might happen as a result of the charge or the inmate appears unable to actively participate in the hearing as suggested by the following:

Does the inmate know where he is?
Is the inmate appropriately dressed?
Does the inmate make sense?

Does the inmate know what date it is?
Is inmate able to speak coherently?
Are the inmate's statements logical and organized or unusual?

Yes No

Should the inmate be referred for mental health evaluation of competency? Yes No

-- If Yes, referred for mental health evaluation/consultation on: _____

MENTAL HEALTH STAFF:

Date request for consult received: 6-17-04

Date consult returned: 6-17-04

Is the inmate competent to participate in the hearing?

If NO, why is the inmate not competent?

Yes No

If NO, what treatment will assist the inmate in becoming competent?

Are there mental health issues that may have impacted inmate's behavior at the time of the charge?
If YES, briefly describe the issues:

Yes No

Are there mental health issues to be considered regarding disposition if the inmate is found guilty?
If YES, briefly describe the issues and possible relation to the disposition:

Yes No

Does mental health staff want to be present at the disciplinary hearing to provide input?

Mental Health Staff Member: Mrs. A. C. Cyrus Phone Contact: 132

Yes No

DISCIPLINARY HEARING:

Does the inmate appear to be competent to participate in the hearing?
Have the mental health recommendations been considered?

Yes No
Yes No

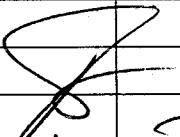
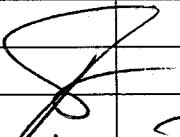
Hearing Officer: _____ Date: _____

Inmate Name	AIS #
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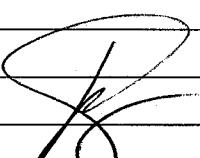
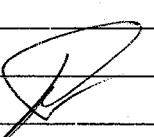
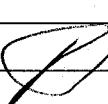
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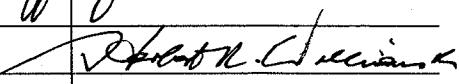
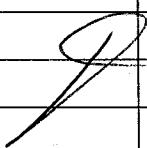
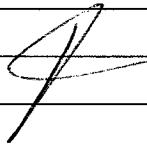
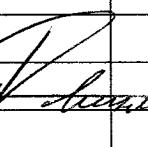
Hampton was reviewed in the staff meeting and interviewed by me in the infirmary. He was able to communicate with me in a clear fashion and he said he could present his side of the matter to the hearing officer. He would like help from his counselor but did not know. The mt staff has not expressed an interest in this matter.

DATE	TIME	NOTES	SIGNATURE
6/18/04	5:15PM	seen in seg following reports of aggressive behavior. He claims "vise" of "dev't" Insomnia	
	6:00	Alert Relatively calm Organized No threats now to self or others	
	7:00	Severe personality d/o w/ episodes of regression	The potential benefits and side effects of <u>Thioridazine</u> within the dosage range of
	8:00	Thioridazine x 3d Support	50/d have been discussed with the inmate and the inmate has agreed to accept the medication.
			
6/21/04	5:00	5) Called yesterday abt Mr. Hampton Running into the wall in Seg.	
6:30	7:00	0) placed in 5pt Restraints in 1A/1C for his own protection Sleeps soundly (out of restraint this morning).	
		PP no chg. Return to Segregation.	
6/21/04		Mental Health Disciplinary Process file Z. Perry/M. Hay	

Patient's Name, (Last, First, Middle)	AIS#	Age	R/S	Facility
Hampton, Randall	226420	21	13m	1cf

DATE	TIME	NOTES	SIGNATURE
6/16/04	1:20 pm	5) Still Threat, self inj: Will allow 1 hand free to use the knife - However his THREAT to fall backward off the sink or his head mandates continued RESTRAINT.	
6/17/04	6:50 am	5) Seen in IN-P. Rm. PT Slept all night - S was not on nemonication 0) Will discuss w/ STAFF & SAWK A) What Action PT. TO SG. or Doc Present.	
6/17/04	8:40 am	Released to Doc Present. Off suicide watch.	

Patient's Name, (Last, First, Middle)	AIS#	Age	R/S	Facility
Stapton, Randie	226420	21	BR	BCC

DATE	TIME	NOTES	SIGNATURE
06/15/04	10:15 AM	<p>5- Drank hair shampoo.</p> <p>0- Challenged physician aggressive towards No staff</p> <p>A- Shoving up undigested food</p> <p>P- Seen by MD - Sanders.</p> <p>PT Sedan administered in RT patient's reaction.</p> <p>Placed in HCC in 5 pt restraint</p> <p>PD patient administered</p> <p>C- Notified nursing staff of only distress</p>	
6/16/04		PT calm per. Will place of 5 pt restraint.	
14 ³⁰			
6/16/04		PT calm th a. Voluntary parity Will return to SG.	
6/16/04	8:15 AM	<p>5) PT Promised him cell in SG.</p> <p>6) Began to HW May 2 Sun - Threat to file brochure off th Sun.</p> <p>7) As above & before</p> <p>8) PT again in 5 pt restraint to Sun at Sun.</p>	
6/16/04	10 ³⁰	Reports voice tally him to staff clearly and patient.	

Patient's Name, (Last, First, Middle)	AIS#	Age	HS	Facility
Hampton, Paradise	226420	67 1/83	B/M	BCCR

DATE	TIME	NOTES	SIGNATURE
5/6/04		<p>5) Patient is & Referred. INITIALLY WAS SLEEPING WHEN I WENT IN</p> <p>0) NO Anger evident initially BUT once he woke up STANDS BARRY ON THE DOOR & WALKS PACIFIC</p> <p>ANOTHER TIME CELL IN DOOR BARRY FASHION & HIS VISITS BENDED UP,</p> <p>A) EX POSITIVE PO. / INTRACRANIAL DISURE / ASDP (W/ RESIDUAL BRAIN DAMAGE?)</p> <p>(See Dr. Kerr's note of 10/20/03.)</p> <p>B) AT THIS POINT IN TIME He is present a security probe TO INTRACRANIAL. However will get A SKULL X TO DETERMINE DATE & FOR ALL IF IT HAS A STEEL PLATE THERE. X</p>	
5/5/04		<p>Dr. Bill Sanders</p> <p>- Pt going down the stairs Accusation is Capt. will be - He goes - He is loud & can't understand.</p> <p>J</p>	
5/6/04		<p>X-ray - NO STEEL PLATE OR BURN Holes in the SKULL.</p>	
6/15/04		<p>5) Act UP again - Run 1400000 - Draw SHAMPOO</p> <p>0) no x-ray</p> <p>A) rights about DISURE</p> <p>B) Pt is in How a Small cell in SPT patient</p> <p>J</p>	

Patient's Name, (Last, First, Middle)	AIS#	Age	R/S	Facility
Hampton, Rawlison	226 426	21	Br	BCCP

Monthly Activities

Date 3.11.04

EM Name Randall Hampton AIS# 226420

Was offered the following recreational activities during the month of

March 04, activities: Mental stimulation
worksheet, open recreation, music therapy,
current events, bingo, conflict resolution,
Scopel, cartoons, western, movies, under-
standing violence, moral + values, stress mgmt.

His level of participation was generally active/marginal/reluctant/resistant/refused to participate in the previously mentioned group(s). This is consistent/inconsistent with his use of recreational services to date. Affect was generally angry/hostile/animated/blunt/euthymic/flat/inappropriate/neutral/sad. Mood appeared angry/sad/neutral/euthymic/depressed/surly/belligerent/indifferent. Hygiene was good/WNL/poor. EM was generally on time/late. General appearance was Neat/WNL/Disheveled/Shabby. Speech was generally clear/mumbling/slurred/unintelligible. Interpersonal interactions were generally relevant/irrelevant/insightful/superficial/confrontational/Indifferent/no interaction.

Comments: _____

Therapeutic services will continue to be offered on a regular basis. His level of participation will be/has been communicated to his treatment team.

Signature

DATE	TIME	NOTES	SIGNATURE
5/25/04		<p><u>Treatment Review</u></p> <p>RANDALL Hampton has seizures occasionally. Reports thinking other people are to get him. Spends most of time exercising & reading books. Confused affect. Stable.</p> <p>P- Next session is scheduled in two weeks.</p>	
5/4/04.	5:10 AM	<p>P) PT was seen in visit room where he was staying. Told him about his condition, exercise & rights to privacy. He was visiting his mother & father at the time, & was asked to witness the unprovoked nature of the patient.</p> <p>Q) Expressive speech out of context threat - to do harm & want to be killed. "You are next to kill me" etc.</p> <p>A) Acute explosive psychotic reaction of <u>rage</u>!</p> <p>P) Handout & attain IM - SPT restraint & suicide watch in inf.</p>	A. Peter A, MHP
5/4/04.	5:12 AM	<p>S) PT asleep & car</p> <p>Q) W/ release of 5 pt. restraint.</p>	P
			P

Patient's Name, (Last, First, Middle)	AIS#	Age	R/S	Facility
Hampton, Randall	2264120		BM	BCF

DISCIPLINARY PROGRESS NO. 11

DATE	TIME	NOTES	SIGNATURE
-29-04		Treatment Notes:	
		(S) Patient sleeps the "Majority" of the Day. Patient does not participate in any group activities or Exercising offered by offices. I believe my sedation is causing him to sleep like this. I am not complaining about it because it keeps me out of trouble. MHP has noticed that Patient has not gotten any disciplinary or citations. Patient seems to be functioning well for the PTI. According to MHP Medication compliance is in order.	
		(S) Patient's speech was slurred however was understandable. Appearance was acceptable.	
		(A) Schizophrenic Disorder	
		(P) Will continue to provide individual therapy with encouragement of medication compliance	
		<u>S. Hahn, M.S., MHP</u>	

S. Hahn, M.S., MHP

Patient's Name, (Last, First, Middle)	AIS#	Age	R/S	Facility
Hampton, Randell	226420		8M	BCCF

Monthly Activities

Date 2.12.04

IM Name: Randell Hampton AIS# 226420

Was offered the following recreational activities during the month of:

February 04, activities: Mental stimulation worksheet, Open recreation, bingo, music therapy, bingo, current events, gospel, music, cartoon, moral + values, hygiene, social skills

His level of participation was generally active/marginal/reluctant/resistant/refused to participate in the previously mentioned group(s). This is consistent/inconsistent with his use of recreational services to date. Affect was generally angry/hostile/animated/blunt/euthymic/flat/inappropriate/neutral/sad. Mood appeared angry/sad/neutral/euthymic/depressed/surly/belligerent/indifferent. Hygiene was good/WNL/poor. IM was generally on time/late. General appearance was Neat/WNL/Disheveled/Shabby. Speech was generally clear/mumbling/slurred/unintelligible. Interpersonal interactions were generally relevant/irrelevant/insightful/superficial/confrontational/Indifferent/no interaction.

Comments: _____

Therapeutic services will continue to be offered on a regular basis. His level of participation will be/has been communicated to his treatment team.

Signature 

Monthly Activities

Date 12.10.03

IM Name Randell Hampton AIS# 226420

Was offered the following recreational activities during the month of:

Spec 03, activities: Lijr, open recreation, mental stimulation work sheet, self-esteem, art therapy, moral & values, coping skills, Dreas, mgmt, gospel movies, music therapy.

His level of participation was generally active/marginal/reluctant/resistant/refused to participate in the previously mentioned group(s). This is consistent/inconsistent with his use of recreational services to date. Affect was generally angry/hostile/animated/blunt/euthymic/flat/inappropriate/neutral/sad. Mood appeared angry/sad/neutral/euthymic/depressed/surly/belligerent/indifferent. Hygiene was good/WNL poor. IM was generally on time/late. General appearance was Neat/WNL Disheveled/Shabby. Speech was generally clear/mumbling/slurred/unintelligible. Interpersonal interactions were generally relevant/irrelevant/insightful/superficial/confrontational/Indifferent/no interaction.

Comments: _____

Therapeutic services will continue to be offered on a regular basis. His level of participation will be/has been communicated to his treatment team.

J. Brey

Signature

INTERDISCIPLINARY PROGRESS NOTES

DATE TIME

NOTES

SIGNATURE

12-18-03

Treatment Notes:

S- Patient has not had a recent episode of any suicide attempts or any verbal references to suicide. Concerns about the client's suicidal ideations were brought up in an open and honest manner. Emphasis was placed on the permanent nature of using suicide as a solution for a temporary problem or emotional state. Patient at one point was not taking his medication due to fear someone may to hurt him.

- D- Patient was agitated, angry and paranoid.

- A- Patient seem to have trouble controlling his behavior as well as uncooperation towards DOB officers

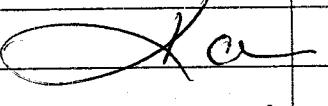
- P- Patient was reminded to focus on the portion of himself that wants to go on living. Patient was also encouraged to change irrational behavior.

J. Hahn M.S. MHP

Patient's Name, (Last, First, Middle)

Patient's Name, (Last, First, Middle)	AIS#	Age	R/S	Facility
HAMPTON, Randall	224420		S/M	BCCF

INTERDISCIPLINARY PROGRESS NOTES

DATE	TIME	NOTES	SIGNATURE
11/7/03	5.	Escalating in safe cell again.	
1245		Loud, pacing, but able to slow down and converse. No suicidal threats now, but fears he "can't take it." Agrees to accept pr Thorazine. Contracts for safety.	
		D. Agitated	
		A. He continues to have difficulty managing his emotions / behavior, and is in danger of regressing. Not judged acutely suicidal.	
		P. Thorazine prn support	
			
11/7/03	5.	seen again in safe cell. Agitated, but able to verbally de-escalate. Declines further Rx for the moment. No new threats.	
1340			
		D. Easily agitated; gets fearful, paces.	
		A. Ongoing, fluctuating crisis situation, though he calms a little easier now.	
		P. Will make IM Ativan available in addition to Thorazine. Inmate agrees.	
		Ongoing support in safe cell	

Patient's Name, (Last, First, Middle)	AIS#	Age	R/S	Facility
Hampton, R	226420			

Monthly Activities

Date: 1/13/07

IM Name: Randell Hampton AIS# 326430

Was offered the following recreational activities during the month of:

January 07. Activities: Mental stimulation worksheet, open recreation, Lingo, Social skills, Current events, movies, music therapy, Current, Gospel, Social skills.

His level of participation was generally active/marginal/reluctant/resistant/refused to participate in the previously mentioned group(s). This is consistent/inconsistent with his use of recreational services to date. Affect was generally angry/hostile/animated/blunt/euthymic/flat/inappropriate/neutral/sad. Mood appeared angry/sad/neutral/euthymic/depressed/surly/belligerent/indifferent. Hygiene was good/~~poor~~. IM was generally on time/late. General appearance was Neat/~~WNL~~Disheveled/Shabby. Speech was generally clear/mumbling/slurred/unintelligible. Interpersonal interactions were generally relevant/irrelevant/insightful/superficial/confrontational/Indifferent/no interaction.

Comments: _____

Therapeutic services will continue to be offered on a regular basis. His level of participation will be/has been communicated to his treatment team.

J. Brum —
Signature

INTERDISCIPLINARY PROGRESS NOTES

DATE	TIME	NOTES	SIGNATURE
11/6/03	1320	<p>S. Seen in safe cell this AM and again this afternoon. He says he's hungry and would prefer to return to seg. He is not threatening to harm himself, and we had a frank discussion of his history of making suicidal statements and how this has kept him on close watch and restricted to bag meals.</p> <p>O. Alert, easily frustrated but able to develop rapport. Speech is spontaneous and clear. No objective signs of psychosis. He's able to contract for safety and understand all of our conversation about options.</p> <p>A. (Severe) Persuasibility D/o ("cluster B")</p> <p>P. He declines any meds. We'll D/C suicide watch (MHO only) and I'll see him in safe cell in AM</p>	
11/7/03	1100	<p>S. Seen in safe cell. He feels better. No major outbursts. He requests to remain in safe cell through weekend, then go to seg, as he fears he'll have a challenge coping there and could "go off" unless we're around to help.</p> <p>O. Polite. More relaxed. No suicidal threats w/r/t crisis resolving. Will keep on MHO through Monday AM, then to seg</p>	
Patient's Name, (Last, First, Middle)		AIS#	Age
Hampton, Randall		226420	R/S
			Facility
			BCCF

INTERDISCIPLINARY PROGRESS NOTES

DATE	TIME	NOTES	SIGNATURE
11-6-03		<p><u>Treatment Note:</u></p> <p>The patient was asked to describe the frequency and intensity of his suicidal thoughts and feelings, the details of any recent suicide plan, and the history of past attempts. Patient was encouraged to be forthright regarding the current strength of his suicidal feelings and the ability to control such suicidal urges. Patient is being monitored on an as-needed basis for his suicide potential.</p>	<p>J. Holmes M.S., MFT Associate MHP</p>

Patient's Name, (Last, First, Middle)	AIS#	Age	R/S	Facility
HAMPTON, RANDALL	226 420		B/M	BCCF

INTERDISCIPLINARY PROGRESS NOTES

DATE

TIME

NOTES

SIGNATURE

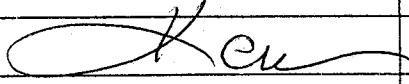
11-09-03	1000 ⁰⁰	<p>L. Pt awakened in infirmary, initially beating fists on door & then banging head on door. Lt Stevens here to help de-escalate situation. Pt does not want 'stat' explained to pt our obligation to protect him from self-injury. Explain that if he does not stop banging head, medication and/or restraints will be needed. Pt expressed understanding of agreement. Rague suicide references - denies plan</p> <p>D. Fearful, poor eye contact</p> <p>A. As per Dr Kern, acute disruptive & self-injurious behavior</p> <p>P. Lt Stevens took pt outside for break</p> <p>Pt understands that further self-injury / head-banging will require meds / restraints.</p>	M. WILFORD
11/15/03		<p>Hampton is calm. Tdy.</p> <p>He is dressing self. Min.</p> <p>Pt still act as if sick - not act out</p> <p>14 but another of in POC. & Mr. Teller will do.</p>	
11/15/03	12:30	<p>Pt Banging his head agt 8:30 AM</p> <p>W/ a sm slt of Hach & art.</p> <p>Pt calm but down</p>	J

Patient's Name, (Last, First, Middle)	AIS#	Age	R/S	Facility
Hampton, Randall	226420	20	BM	BCRF

INTERDISCIPLINARY PROGRESS NOTES

Patient's Name, (Last, First, Middle)	AIS#	Age	R/S	Facility
Hampton, Randall	226420	20	B/m	BCCF

INTERDISCIPLINARY PROGRESS NOTES

DATE	TIME	NOTES	SIGNATURE
11/3/03	S. 0650	<p>Seen in safe cell.</p> <p>He says he was "beaten" by officers and he wants to transfer out of this camp. He was observed in the safe cell deliberately falling to the floor, per officer, but shows no evidence of injuries to my observation. He says he was suicidal because he thought "the police" were going to harm him.</p> <p>O. Now calm; initially says he "can't remember", when asked what happened, then relates events in some detail. He says he won't forget what officers did to him and he may harm one of them.</p> <p>He does not exhibit any psychotic features, nor does he appear depressed.</p>	
	A.	Dx likely primary Axis II (ASPD w/ long hx of conflict w/ authorities)	
	P.	Continue safe cell pending review of disposition options. Discussed w/ Dr. Sanders.	
			Kern
		Kern M.D.	
late entry	11/02/03 1400	<p>Haladol 10mg IM & Ativan-2mg IM given in RT gluteal per order Dr. Sanders. — [Signature]</p>	

Patient's Name, (Last, First, Middle)	AIS#	Age	R/S	Facility
Hampton, R	226420		Bm	BCCF

INTERDISCIPLINARY PROGRESS NOTES

DATE	TIME	NOTES	SIGNATURE
10/28/03	5:00	<p>S. Various c/o incl. "leg hurts", "flashbacks". Prim hx "voices", "seeing things." Dramatically reports hx multiple attempts at self-harm, but no intent / plan now.</p> <p>o. Alert, spontaneous. Voices has whispering quality, but is nl rate. Affect constricted. Vague ST, but no plan / threat. No threats to others. No objective psychotic features. Tends to be overinclusive / tangential</p> <p>At Taylor Hardin SMF 5/2/02 - 7/9/02 w/ dx of I. Malingering II. Poly substance abuse + III. ASPD IV. Pseudo seizures</p> <p>A. Questionable dx on Axis I. ASPD + Borderline PD(?)</p> <p>P. D/C Prozac (not taking anyway) Considering D/C Haldol - discuss next visit; monitor</p>	
10/28/03		<p><i>Kemmer</i></p> <p>Note: Inmate is competent enough to participate in disciplinary hearing</p> <p><i>Henry/Mitof</i></p>	

Patient's Name, (Last, First, Middle)	AIS#	Age	R/S	Facility
Hampton, R	226420		B/M	BCCP

**ALABAMA DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES
MENTAL HEALTH CONSULTATION TO DISCIPLINARY PROCESS**

Inmate Name: HAMPTON, RANDALL AIS#: 226420
 Institution: Bullock Date of Disciplinary Report: _____

Is the inmate currently on the mental health caseload? Yes No
 If Yes, referred for mental health evaluation/consultation on: _____

HEARING OFFICER:

Hearing officer must refer the inmate for mental health consultation if the inmate appears unable to understand what the charge is and what might happen as a result of the charge or the inmate appears unable to actively participate in the hearing as suggested by the following:

Does the inmate know where he is?	Does the inmate know what date it is?	Does inmate know why he is seeing hearing officer?
Is the inmate appropriately dressed?	Is inmate able to speak coherently?	Does the inmate avoid eye contact?
Does the inmate make sense?	Are the inmate's statements logical and organized or unusual?	

Should the inmate be referred for mental health evaluation of competency? Yes No
 If Yes, referred for mental health evaluation/consultation on: _____

MENTAL HEALTH STAFF:

Date request for consult received: 11-10-03 Date consult returned: 11-10-03

Is the inmate competent to participate in the hearing?
 If NO, why is the inmate not competent?

Yes

No

If NO, what treatment will assist the inmate in becoming competent?

Are there mental health issues that may have impacted inmate's behavior at the time of the charge?
 If YES, briefly describe the issues:

Yes

No

Are there mental health issues to be considered regarding disposition if inmate found guilty?
 If YES, briefly describe the issues and possible relation to the disposition:

Yes

No

Does mental health staff want to be present at the disciplinary hearing to provide input?

Mental Health Staff Member: Mrs. Haynes Phone Contact: 132

Yes

No

DISCIPLINARY HEARING:

Does the inmate appear to be competent to participate in the hearing?
 Have the mental health recommendations been considered?

Yes
 Yes

No
 No

Hearing Officer: Kelvin Syrett Date: 11-7-03

Inmate Name	AIS #
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5 mental health status was reviewed in an open mental health staff meeting. No one thought going to disciplinary court was a problem. This thinking is clear public. Tink Tink

TAYLOR HARDIN SECURE MEDICAL FACILITY

HOSPITALIZATION SUMMARY

 * CONFIDENTIAL & PRIVILEGED *
 * For Professional Use Only *
 * Not for Publication *
 * Not to be Used Against *
 * Patient's Interest *

NAME: Hampton, Randall

FILE NO. 06 50 32 96

SEX: Male

MARITAL STATUS: Single

DATE OF BIRTH: 10/15/83

S.S. #: 421-17-2669

ENT ADMISSION DATE: 05/02/02

MISSION STATUS: TX-IST/MSO

LEAVE DATE: 07/09/02

LEAVE STATUS: Discharge

PATIENT'S NEXT-OF-KIN: Barbara Hampton

Relationship: Mother

Address: 6385 Airport Road
Elmore, AL 36025

Phone: (334) 290-3723

PROVISIONAL DIAGNOSES

AXIS

Psychotic Disorder, NOS, Rule Out

I

Major Depressive Disorder, Single, Rule Out

I

Other (or Unknown) Substance Abuse, Rule Out

I

Personality Disorder, NOS, Rule Out

II

Epilepsy, NOS – Not Intract

III

GAF: 35

V

FINAL DIAGNOSES

AXIS

Malingering

I

Polysubstance Abuse

I

Antisocial Personality Disorder

II

TAYLOR HARDIN SECURE
MEDICAL FACILITY
Tuscaloosa, Alabama

NAME: Hampton, Randall
FILE NO.: 06 50 32 96

HOSPITALIZATION SUMMARY

PAGE 2

Pseudoseizures, History of Seizures and Complains of Gastritis
Moderate
GAF: 55

III
IV
V

OTHER MEDICAL DIAGNOSES

None.

PROGNOSIS FOR PRINCIPAL DIAGNOSES

Guarded.

DISCHARGE MEDICATIONS

1. Phenobarbital 30 mg. po q. hs
2. Tegretol 300 mg. po b.i.d.
3. Benadryl 100 mg. po q. hs
4. Zantac 150 mg. po b.i.d.

MEDICAL SUMMARY

Mr. Hampton was seen for a physical examination on May 3, 2002 conducted by Alice Cunningham, CRNP. The patient reported a history of a seizure disorder, past suicide attempts, putting his head into a toilet, cutting himself and trying to starve himself to death. He had numerous scars and tattoos including a five-inch scar on left lateral neck, long scar on left posterior forearm and four-inch scar on right wrist.

At the time of admission, Mr. Hampton weighed 150 pounds with an ideal body weight range of 154 to 166 pounds. He was placed on a regular diet. Admission lab work indicated the following out of range results: SGOT (AST) 53, SGPT (ALT) 101, WBC 3.98, RBC 4.07, MCV 96.1, MCH 34.4, and Tegretol level 2. Syphilis serology was nonreactive. AIMS testing indicated a score of zero. PPD was negative on 05/07/01.